

Guideline for SSI

Name:

Age:

Sex:

Education:

Profession:

Do you own a mobile phone?

How do you use it?

Do you have TV?

Do you have access to the internet?

Do you read newspaper?

- Which health facility do you prefer to go to for health care during pregnancy? Why do you prefer this health facility?
- Have you used clinics of Urban Primary Health Care Service Delivery Project (UPHCSDP) for care seeking during pregnancy? Please explain the reason for not using the service (if service was not used)
- Do they provide any nutritional services? What are your experiences in receiving such services? [perception of availability of services, satisfaction with the service provision (cleanliness, behaviour, waiting time)]
- What should the nutrition services look like in these healthcare facilities? (probe: time taken, fees, referral, outreach)
- How would you like the health facility to reach you with information and reminders? (probe: use of media, how to develop trust in the info received)
- What would make you trust the information you receive from different sources? (probe media, institution, person)

KII Guideline for service provider/program personnel

Name:

Age:

Sex:

Education:

Job title:

- Please tell us the types of nutrition services you provide for the pregnant mothers and young children currently? Give us some examples (probe: growth monitoring, counselling, provision of IFA, Calcium or other products, reminder, referral)

- Do you face any barriers in providing such services? (probe: growth monitoring, counselling, provision of IFA, Calcium or other products, equipment, human resources, workload, patient flow, reminder, referral or others)
- Is there any challenge for pregnant women and young mothers in accessing nutrition services at your facility?
- What can help to improve the nutrition services you provide at present (probe: training, supplies, time, mandate)
- What do you think is a good way of reaching mothers with nutrition information and services (Probe: media, outreach, use of mobile phone, linking with community groups, community leaders)?
- Please suggest who can be engaged to strengthen the nutrition services provision through health care facilities (community group, community leader, others)?

Checklist for Facility Observation during ANC

1	Observation Starting time:	_____ (HH:MM(24 hours)
2	Observation End time:	_____ (HH:MM(24 hours)
3	Information of Pregnant Women/ Mother of children	
3.1	No of ANC Visit :	<input type="checkbox"/> 1 st Visit-----1 <input type="checkbox"/> 2 nd Visit-----2 <input type="checkbox"/> 3 rd Visit-----3 <input type="checkbox"/> 4 th Visit-----4
3.2	Age of pregnant mother (in years):	_____ Years

4	Information During Observation	
Note: <i>Carefully observe the ANC check-up session conducted by the provider and put a (v) in the applicable box.</i>		
No	Observation Points	Responses
4.1	Does the facility have space dedicated for nutrition counselling?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4.2	Does the health care provider greet the woman with respect and dignity?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4.3	Is the pregnant women given any nutrition advice during ANC?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4.4	Does the health care provider, or another staff, weigh and record the WEIGHT of the woman today?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4.6	Does the health care provider, or another staff, examined ANAEMIA in eyes (Lower palpebral fissure) of the woman?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

5	What ADVICE (S) does the health care provider provide to the women today? <i>Put a (v) in the applicable box</i>	
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5.1	To take more food	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5.2	To take balanced and diverse diet	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5.3	To take animal source foods	
5.4	To take seasonal/available fruits	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5.5	To take green/coloured vegetables	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5.6	To drink more water	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5.7	To take iodized salt	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5.8	Told to visit for regular antenatal check-ups (ANC)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5.9	Told to take routine iron and folic acid(IFA)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5.10	Told about the importance of breastfeeding	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5.11	Initiation of breastfeeding within one hour	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5.12	Immunization	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5.13	Provided Iron-Folate tablet (IFA)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5.14	Provided Calcium tablet	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5.15	Does the health care provider explain when to return for a follow-up visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5.16	Does the health care provider thank the women after the ANC session?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5.17	Does the delivery packages include formula?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Please review the entire observation checklist for any **missing points**,
Fill up with (v) in appropriate box and finish the observation

Observation Checklist for Sick Under-Two Paediatric services

1	Surveyor Name and ID: _____ ____/____/____	5B02 Date: _____ ____/____/____
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	General Information of health facility	Code
2	Observation Starting time:	_____ (HH:MM(24 hours)
3	Observation End time:	_____ (HH:MM(24 hours)
4	Facility code	_____/_____/_____
5	Information on the under-two child	
5.1	Age of child:	_____ _____ in weeks
5.2	Sex of child:	<input type="radio"/> Male-----1 <input type="radio"/> Female -----2

Information on the under-two years child during <i>pediatric session</i>		
<i>Note: Carefully observe the pediatric session conducted by the provider and put a (v) in the applicable box</i>		
No	Observation Points	Responses
6.1	Does the health care provider have any IMCI register book?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6.2	Does the health care provider, or another staff, weigh and record the WEIGHT of the child today?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6.3	Does the health care provider, or another staff, measure height/ length and record the height/length of the child today?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6.4	Does health care provider check child's weight against a GROWTH CHART ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6.5	Does health care provider ask about BREASTFEEDING ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6.6	Does health care provider ask whether the child takes any other FOODS/FLUIDS ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6.7	Does health care provider ask about FEEDING during illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6.8	Does the health care provider provide Zinc tablet? (for diarrhoea)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6.9	Did the health care provider advise the caregiver on Exclusive breastfeeding??	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6.10	Does the health care provider explain the need to continue breastfeeding at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6.11	Did the health care provider advise the caregiver on frequency of feeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6.12	Does the health care provider use the IMCI chart booklet at any time during the management of the child?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

6.13	Does health care provider use any visual job aids for demonstrating IYCF practice?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6.14	Use of BCC materials to raise awareness on nutrition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6.15	Prescribe/Provide Vitamin-A capsules	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6.16	Did the health care provider advise the caregiver on Introduce solid/semi solid foods?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6.17	Did the health care provider advise the caregiver on Dietary diversity?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

*Please review the entire observation checklist for any **missing points**,
Fill up with (v) in appropriate box and finish the observation.*
